

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1914	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2012
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NAME OF PROVIDER OR SUPPLIER

LAKESHORE HEARTLAND

STREET ADDRESS, CITY, STATE, ZIP CODE

3025 FERNBROOK LANE
NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments During annual Licensure survey conducted on October 22-25, 2012, at Lakeshore Heartland, no deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes	N 000		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Administrator

(X6) DATE

11/08/12

STATE FORM

6509

LU9011

If continuation sheet 1 of 1